MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, October 18, 2001
10:05 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:
Public comment

MR. ZESK: First of all, I want to introduce myself. My name is Ed Zesk. I am the president of Aging 2000, a non-profit consumer organization based in Rhode Island that many people feel is a model for this Medicare consumer coalition concept.

I also am the secretary-treasurer of the National Coalition of Consumer Coalitions on Aging who are involved in helping to develop this proposal, and chair the committee on Medicare managed care.

I also serve as a member of the Advisory Panel on Medicare Education that was created by the Balanced Budget Act to advise the Secretary of Health and Human Services and the Administrator of the agency formerly known as HCFA on issues relating to Medicare education.

I'm very disappointed and somewhat surprised at the recommendation from staff on this issue. I was actually at that meeting on July 17th and while I think there was a lot of questions being raised, some of those questions indicated that members of that group hadn't actually read the feasibility study. I won't disagree with the staff assessment that the majority of people were opposed to it, but I don't feel that adequate discussion and answers to some of those questions had an opportunity to take place. And I wish that some of the authors of that report had been there in the room at the time.

One of the recommendations, I've been asked by the fellow members of the Panel on Medicare Education, to chair the committee to draft our report to Secretary Thompson and Administrator Scully on the status of Medicare education currently in this country. And I have to tell you that the situation is very bleak.

Information that we've received, testimony that we've received from places like Kaiser Family Foundation indicate that the majority of Medicare beneficiaries don't understand the Medicare program, much less the choices that are being offered to them. And that fully 50 percent of Medicare beneficiaries currently enrolled in managed care plans don't know that they're in managed care plans.

Now we think that the national Medicare education program is woefully underfunded, and that CMS has done a great job with limited resources in what it has been able to do. But the idea here of the Medicare consumer coalition is to leverage existing resources out in the community that not only can do a better job of helping Medicare beneficiaries understand the choices that are available to them in that marketplace in much greater detail than any centralized information source is going to be able to provide them, but also to protect the vulnerable populations. People with low literacy, cultural issues, language issues, who through coalitions of consumer organizations that already represent them, that they trust can be a source of information for them, that's going to help them make a truly informed decision.

We're not there yet. We're not even close to being where we want to be on this issue. But unless we take advantage of those

resources, there's never going to be enough money to do a fully adequate job.

Now on the issue of having the sophistication or expertise to be able to negotiate, on my board of directors are examples of the kinds of resources I'm talking about. I've got a retired bank president who was deputy treasurer of the state of Rhode Island, the former deputy director of health, the former chief policy advisor to the governor, a senior partner in the biggest law firm in the state, many physicians and nurses. Certainly the expertise is there to be able to represent consumers.

These kinds of purchasing cooperatives already exist. If you're a retiree of General Motors or if you're a retired member of a union, you've already got somebody using the buying power of your fellow members or your fellow retirees to negotiate with health plans.

Why is it that just because you're a Medicare beneficiary who didn't retire from the big corporation, or weren't a union member, that you wouldn't have access to having that kind of leverage?

I would correct one point that was made before. This is a strictly voluntary purchasing cooperative idea. Anybody can join. And anybody can join at any time.

So in answer to the question of whether or not we could, for example in a state like Rhode Island, get enough people to join a voluntary purchasing cooperative that would allow us to sit down and negotiate for coverage, cost issues with health plans, Medigap insurance, long-term care insurance providers, and pharmacy benefit management companies, I assure you that we could. And we're not asking to do this around the country. We're saying let us do some very limited demonstration projects in selected communities where the ability is already there to do it, overseen by CMS.

Thank you.

MR. BEDLAN: Good morning. I'm Howard Bedlan. I also attended the meeting on the 17th. I'm the vice president for public policy and advocacy with NCOA.

First, I do appreciate the opportunity to comment before a decision is made. I think that's the appropriate process personally.

I do want to first respectfully disagree with the conclusion that it was a 90/10 split. I don't personally think that was accurate. I do think there were a lot of concerns that were raised, which is in large part the purpose of the meeting, so that those concerns could be put on the table. I think that a lot of the responses, in terms of how you design these, would respond quite effectively to the concerns that were raised.

I have not had an opportunity to see the Mathematica report so I can't comment specifically. But I do want to at least respond to what we have seen, which was the bulleted points earlier.

I would argue there are four issues that have primarily come up on the 17th, and from the presentation that we saw today. Number one is what is the value added of these kinds of coalitions. Number two was on the information side, how they

might interact with the state health insurance programs. The third had to do with an issue that was debated quite a lot on the 17th, whether there would be a conflict if the same entity did the information and purchasing function. And finally, the stability and the numbers in terms of a purchasing coalition.

In terms of value added, I do think, as my boss mentioned earlier, the fact that these would be non-governmental entities would certainly be a value added, in terms of their greater flexibility, the ombudsman and advocacy role that they would be able to take that SHIPs are not currently able to provide. I think the distribution networks of large coalitions would significant enhance the number of individuals who got good information.

While this could happen today, it's not happening for the most part. I think we need to think about why it's not happening.

Third, in contrast to the staff's conclusion, I think this would improve coordination. That's certainly the purpose. We would hope that this would be bringing together all of the different components and make it a lot easier and improve coordination significantly.

And finally, I think these could be used to leverage private dollars. The question was raised in terms of the funding. I think it's our view that we would be requesting some relatively modest startup costs. By virtue of having a broad base of organizations involved in this, we believe that we would not have to rely upon government dollars for very long, and that we could eventually leverage other dollars, including some modest fees from individuals. We certainly would propose that those fees be waived for lower income individuals.

If you look at the one-pager that we did provide, and I hope you do get a chance to look at it before tomorrow, we do -- for example, on the information coalition side, propose two separate demonstrations for information coalitions. I'm quoting: "one that authorizes and funds the State Health Insurance Programs to form and lead the coalitions, and another that includes the SHIPs as members of the coalition along with other groups."

So we certainly recognize the important role that SHIPs would play. And we would argue that we need to test those two different kinds of models.

With regard to purchasing coalitions briefly, I do think there is experience out there right now. Minnesota Senior Federation is one example. Another group who is very interested in this is the Coalition of Wisconsin Aging Groups, who represent overall over 125,000 individuals. These are groups that have been around for a long time. Minnesota Senior Federation began in 1973. Wisconsin Aging Groups was 1978. They are stable, they are certain. They have devoted members. They're well respected, and we do think they could do a great deal in this arena.

With regard to the adverse selection issue, let me just quote briefly from the feasibility study which was referenced. I think it's a legitimate concern, the adverse selection issue, by the way. "The track record with community-based senior organizations is that they direct much of their information and

advocacy programs to the more vulnerable seniors. Hence, it's unclear whether Medicare consumer coalitions would form membership groups that are more or less healthy. Consumer coalitions can contribute to solving the risk selection problem by opening membership to all without economic barriers, keeping closer tabs on the health status and needs of its members, and exerting a countervailing consumer force to providers marketing to healthy seniors."

We would suggest that the information coalitions be separate and distinct from the purchasing coalitions.

And I think I would like to end with a quote from a Health Affairs piece from September/October 2000 that Dr. Reischauer authored along with Len Nichols. "The question before policymakers is whether information about the consequences of alternative reforms can be gathered from carefully implemented and evaluated demonstrations. If not, reforms will have to be implemented cold turkey and disruptive adjustments and corrections will have to be made after the fact."

Thank you.

MR. HACKBARTH: Any other public comments? Let me emphasize that anything we talked about this morning is open to public comment. Any others?

MR. CONNELLY: Good morning members of the Commission. My name is Jerry Connelly, I'm with the American Academy of Family Physicians. I'd like to make just a couple of comments relative to the portion of your discussion this morning that applied to quality improvement standards in the Medicare+Choice and the traditional fee-for-service program.

I'd like to begin by underscoring one comment that Dr. Wakefield mentioned relative to collecting data only one time or at one intervention. I think that it's very important, when we talk about using this data that has really been designed for clinical information, for outcomes purposes or other kinds of purposes such as measuring quality.

I think that it's important that we be careful not to overburden an already overburdened physician and supplier group. The information that you collect, not only should it be collected in my view one time, but it should be specific and it should be relevant to the patient care, the patient experience, to the quality of that care that is delivered. But beyond relevance, it should be valid and it should be reliable. Therefore, it should have some scientific basis and it must be referenced in the literature.

I think what we need to caution ourselves relative to the information that Dr. Reischauer mentioned, in that sometimes this data, as it is reported, can be interpreted inappropriately by the user or by the potential user, or people who have access to the information such as, in this case, the consumer. The improper interpretation of patient satisfaction information, for example, is well documented because in many cases -- or I should say in some, if not frequent cases, a patient has an expectation of receiving a certain kind of care that is not necessarily scientifically valid and reliable. And when they do not receive that kind of care, such as an x-ray in the face of low back pain,

or antibiotics in the face of a cold, then the patient satisfaction that is reported with that experience isn't as high as it would be had they received something that wasn't necessarily valid and reliable in the scientific information.

So I think that it's important not only to collect this information once, but at least pay some semblance of attention to those kinds of issues that I've mentioned here relative to reliability and the basis in scientific fact.

Thank you.

MR. HACKBARTH: Thank you. That's it for this morning. We'll break for lunch and we'll return at 1:30.

[Whereupon, at 12:51 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]